



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

08278
960
Reg. Dist. No.

1. PLACE OF DEATH:
County..... *Somerset*
City or town..... *E Princess Anne*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... *14*
Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

*Noah Bivens Jr.*4. Sex *Male* 5. Color or race *Colored* 6. (a) Single, married, widowed, or divorced *single*

B. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *July 23-1931* 6. (c) If alive, give age years8. AGE: Years *14* Months *1* Days *1* If less than one day hrs. min.9. Birthplace *E Princess Anne Somerset MD* (Town, county, and state)10. Usual occupation *school child*

11. Industry or business

12. Name *Noah Bivens*13. Birthplace *E Princess Anne Somerset*14. Maiden name *Ethel Haagis*15. Birthplace *E Princess Anne Somerset*16. Informant *Dorothy Haagis*Address *E Princess Anne MD*17. Burial *burial* Date thereof *8-27-45* (month) (day) (year)(Burial, cremation, or removal. Which?) Cemetery or crematory *west Po.*Location *E Princess Anne MD*18. Funeral director *James J. Bivens*Address *Princess Anne MD*19. Date rec'd by registrar *August 25 45* R. J. Bivens Reg'd.2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State *MD* County *Somerset*City or town *E Princess Anne* (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *August 24 45* at *2 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10..... 10..... 10.....

and that I last saw him alive on

19.....

Immediate cause of death.....

accidental drowning

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *accident* Date of *8/24/45*Where did injury occur *Princess Anne Somerset MD* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *rubber place*Means of injury *drowned* Injured at work? *No*23. SIGNATURE *Frederick M. Leppard M.D.* M. D. or other *MD*Address *Princess Anne MD* Date signed *8/25/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 750

108279

CERTIFICATE OF DEATH

Reg. Dist. No. 960

1. PLACE OF DEATH:

County Somerset
City or town E. Princess Anne, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? NATIVE

Hospital, institution, or street address where death occurred:

E. Princess Anne

How long in hospital or institution?

3. (a) FULL NAME

Lillie Cannon

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Widow

B. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

1903

8. AGE:

Years 42

Months

Days

If less than one day

hrs. min.

9. Birthplace

West P.O. Somerset County - Md

(Town, county, and state)

10. Usual occupation

House wife - Domestic

11. Industry or business

Henry Cannon

Somerset

Princess Anne

12. Name

Josephine Higgins

13. Birthplace

Princess Anne, Dominc

14. Maiden name

Josephine Higgins

15. Birthplace

Princess Anne, Dominc

16. Informant

Mary Hargrave

Address

Eustis Princess Anne Md

17. Burial

Date thereof Aug 16, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

West Po. Md

Location

East Princess Anne, Md

18. Funeral director

James J. Brown

Address

Princess Anne, Md

19. Date rec'd by registrar

Aug 16, 1945

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town E. Princess Anne
(If outside city or town limits, write RURAL and give nearest town)Street No. Oakville Section Section

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 AUGUST 1945 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 28, 1945, to August 13, 1945

end that I last saw her alive on August 13, 1945

Immediate cause of death

Organic Heart Disease

DURATION

Unknown

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

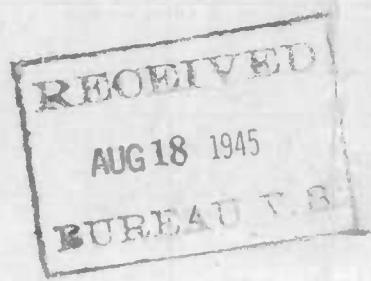
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur J. Brown, M.D.

M. D. or other

Address 115 Willow St. Salisbury Date signed Aug 16/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

08280

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH:

County

Somerset
Crisfield

City or town

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Wesleyan Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 39 hours

Stay in this community (yrs., or mos., or days) 39 hours

3. (a) FULL NAME

4. Sex

7

5. Color or race

W S

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1940

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

29 hrs. min.

9. Birthplace

Crisfield, Somerset, Md
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

12. Name Harold Culbertson

13. Birthplace Illinois

14. Maiden name Mabel Lee Morgan

15. Birthplace Crisfield, Md

16. Informant Harold Lee Morgan Culbertson

Address Crisfield, Md

17. Burial Date thereof 8/7/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Family Burial Ground

Location Crisfield, Maryland

18. Funeral director Wilbur C. Morgan

Address Crisfield, Maryland

19. Date rec'd by registrar 8/7/45 C. E. Collins M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Somerset

City or town Crisfield

Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Chesapeake Ave East

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

Culbertson

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6

1945, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 5, 1945, to Aug. 6, 1945,

and that I last saw him alive on Aug. 5, 1945.

Immediate cause of death

Pneumonia infant

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

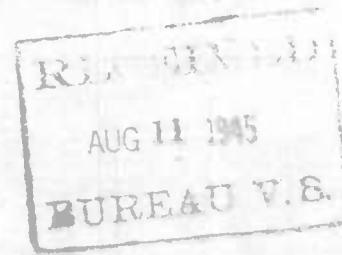
23. SIGNATURE

Sarah M. Peeler, M.D.

M. D. or other

Address Crisfield, Md

Date signed Aug. 7



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

08281 265
Reg. Dist. No.

1. PLACE OF DEATH:

County SomersetCity or town Bresfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 dayHospital, institution, or street address where death occurred: home

How long in hospital or institution?

3. (a) FULL NAME

John E. Mason

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widower6. (b) Name of husband or wife Mary Elizabeth

7. Birth date of deceased (mo., day, yr.)

6. (c) Native, give age years8. AGE: Years 82 Months 6 Days 29 Weeks less than one dayhrs. min. 9. Birthplace Pocomoke City MD

(Town, county, and state)

10. Usual occupation

Waterman (Retired)

11. Industry or business

Boat (Sew)

FATHER

12. Name Mitchell March

MOTHER

13. Birthplace Pocomoke City MD14. Maiden name Wheeler15. Birthplace Maryland16. Informant Jennie J. Schwatka

Address

Bresfield MD17. Burial, cremation, or removal. Which BurialDate thereof 9/2/45

(month) (day) (year)

Cemetery or crematory BresfieldLocation Bresfield MD18. Funeral director Donaldard W. MarshallAddress 306 Main St. Bresfield19. 8/31/45 19.....

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Bresfield (If outside city or town limits, write RURAL and give nearest town)Street No. Broadway (If rural, give LOCATION)2.(a) If veteran, name war W.W. II

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1945 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jane 1945, to Aug 31 1945.and that I last saw her alive on Aug 31 1945.Immediate cause of death Coronary occlusion DURATION1 hourDue to Cardio-vascularArterial diseaseDue to Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE Clara P. Schwatka

M. D. or other

Address Bresfield Date signed Aug 31/45

RECEIVED

SEP 12 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 232

CERTIFICATE OF DEATH

08282

Reg. Dist. No. 265

1. PLACE OF DEATH:

County Somerset

City or town Crisfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Lunkford Mister

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6. (b) Name of husband or wife

Mary Ann Mister

7. Birth date of deceased (mo., day, yr.)	8. (c) If alive, give age	years
April 6, 1861	77	

8. AGE: Years	Months	Days	If less than one day
84	4	9	hrs. min.

9. Birthplace Smith Island, Md.

(Town, county, and state)

10. Usual occupation waterman

11. Industry or business self

FATHER 12. Name James Mister

13. Birthplace Smith Island, Md.

MOTHER 14. Maiden name Tyler

15. Birthplace Smith Island, Md.

16. Informant Mary Ann Mister

Address Crisfield, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/17/45

Cemetery or crematory Asbury

Location Crisfield, Md.

18. Funeral director Howard H. Hubbard

Address 306 Main St., Crisfield, Md.

19. 8/17/45 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Somerset

City or town Crisfield (If outside city or town limits, write RURAL and give nearest town)

Street No. Charlotte Ave (If rural, give LOCATION)

2. (a) If veteran, name war none

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1945, at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 11, 1945, to Aug. 15, 1945,

and that I last saw him alive on Aug. 15, 1945.

Immediate cause of death

Cerebral Hemorrhage

DURATION

4 days

Due to Atherosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

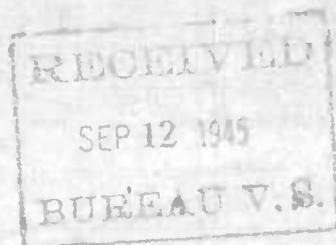
Means of injury

Injured at work?

23. SIGNATURE

S. M. Payton, M.D. M. D. or other

Address Crisfield, Md. Date signed Aug. 17, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

08283

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:

County.....

Somerset

City or town.....

Field Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

10 days

Hospital, Institution, or street address where death occurred:

Ms Cready Memorial Hosp

How long in hospital or institution?.....

10 days

3. (a) FULL NAME

Ellen N. Cutten

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

Female white wedowed

6. (b) Name of husband or wife.....

George Cutten

5. (c) If alive, give age.....years

August 7, 1866

7. Birth date of

deceased (mo., day, yr.)

8. AGE: Years

Months

Days

If less than one day

hrs. min.

79

0

18

9. Birthplace.....

Burw Hill, Worcester Maryland

(Town, county, and state)

10. Usual occupation.....

housewife

11. Industry or business.....

Edward Cutten

MOTHER

FATHER

12. Name.....

Edward

Cutten

Maryland

13. Birthplace.....

Burw

Hill

14. Maiden name.....

Ellen

Evans

15. Birthplace.....

Maryland

16. Informant.....

Mrs

Sadies

Johnson

17. Burial

Cemetery or

crematory.....

Location.....

Margarette

18. Funeral director.....

Margarette

19. Address.....

Pocomoke

City

Md

20. Date rec'd by registrar.....

8/27

1945

21. Signature.....

George C. DeBra

md

22. Address.....

68 E. Main St.

23. M. D. or other

Date signed.....

Aug 27 45

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Worcester

City or town Pocomoke City Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. -

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

August 25 1945, at 10:30 P.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 25 1945, to August 25 1945,

and that I last saw her alive on August 25 1945.

Immediate cause of death.....

A bad cold & fever

succes

DURATION

2 weeks

Due to.....

Colds & cold & fever

Due to.....

Colds & cold & fever

Other conditions.....

Jeanne Cutten

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

George C. DeBra

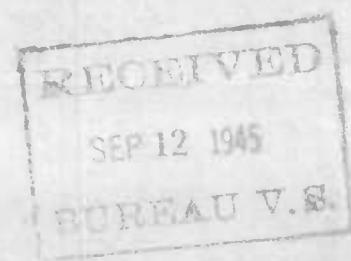
md

Address.....

68 E. Main St.

24. Date signed.....

Aug 27 45



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *120-a*

CERTIFICATE OF DEATH

108284

Reg. Dist. No. *260*

1. PLACE OF DEATH:

County *Somerset*
 City or town *Princess Anne, Md.*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Raymond E. Powell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*M W Married*6. (b) Name of husband or wife *Helen Powell*7. Birth date of deceased (mo., day, yr.) *August 16, 1909*5. (c) If alive, give age *29* years8. AGE: Years *35* Months *11* Days *28* If less than one day *hrs. min.*9. Birthplace *Rehoboth Beach*

(Town, county, and state)

10. Usual occupation *Prospector Business*

11. Industry or business

FATHER 12. Name *Eligah Powell*13. Birthplace *Worcester County*MOTHER 14. Maiden name *Annie Adams*15. Birthplace *Kingston, Md.*16. Informant *Helen Powell*Address *Princess Anne, Md.*17. Burial Date thereof *Aug. 15 1945*
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Episcopal Cemetery*Location *Princess Anne, Md.*18. Funeral director *Wade Dashiel*Address *Princess Anne, Md.*August 14, 1945 *R. A. Johnson*
(Date rec'd by registrar)Registrar
Frank M. Atwood

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Somerset*
 City or town *Princess Anne, Md.*
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug. 13 1945* at *J.P. M*21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *left, 17944* 1944 to *Aug. 15 1945* and that I last saw *h* alive on *Aug. 13 1945*Immediate cause of death *Unsustained*
(Sudden death)

DURATION

Sudden

Due to

Due to

Other conditions *Chronic Alcoholism*
Epilepsy *Goat - related*
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

3. SIGNATURE

Frank M. Atwood M. D. or otherAddress *Princess Anne, Md.* Date signed *8/17/45*

LETTER TO TENNESSEE STATE CHAIRMAN

FROM THE STAFF



Evidence for change of
age & birth date of deceased
is shown on
No. G 97 SEP 6 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08285

CERTIFICATE OF DEATH

Reg. Dlat. No. 760

1. PLACE OF DEATH:
County Somerset
City or town Mt Vernon Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

3. (a) FULL NAME
James Henry Pruitt

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct 26, 1878 8. (c) If alive, give age 69 years

8. AGE: Years 77 Months 7-8 Days It less than one day hrs. min.

9. Birthplace Mt Vernon, Somerset, Md.
(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business Oyster & Crab

MOTHER FATHER 12. Name Robert Pruitt

13. Birthplace Richmond Va.

14. Maiden name Sarah Lawrence

15. Birthplace Wisconsin Co.

16. Informant John Pruitt

Address Mt Vernon Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof Aug 8, 1945 (month) (day) (year)

Cemetery or crematory Asbury M.E.

Location Mt Vernon Md.

18. Funeral director Dale Garrell

Address Princess Anne Md.

Date rec'd by registrar Aug. 8, 1945 Ref. No. 1-2 Johnson

(Date rec'd by registrar) Aug. 8, 1945 (Date signed) Aug. 8, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Somerset
City or town Mt Vernon Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 202
(If rural, give LOCATION)

2. (a) If veteran, name war WW II

3. (b) Social Security Number 202-00-0000

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 5, 1945 to Aug 6, 1945
and that I last saw him alive on Aug 6, 1945

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

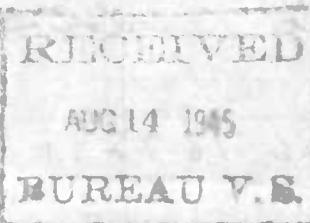
Where did injury occur? (City or town) (County) (State)

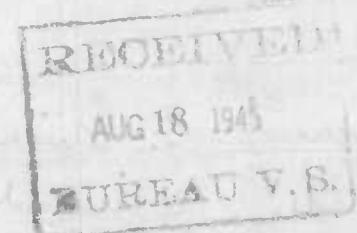
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank Matush M. D. or other

Address Mill Princess Anne Date signed Aug 8, 1945





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

08287

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH:

County... SomersetCity or town... Bonifield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yearHospital, institution, or street address where death occurred: BonifieldHow long in hospital or institution? None

3. (a) FULL NAME

Argie H. Sterling

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Josephine

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sept 12 1878

8. AGE: Years

68

Months

11

Days

13

If less than one day

hrs. min.

9. Birthplace

Bonifield, Md

(Town, county, and state)

10. Usual occupation

Fisherman

11. Industry or business

Sea

FATHER

12. Name Albert G. Sterling13. Birthplace Md

MOTHER

14. Maiden name Sarah G. Sterling15. Birthplace Md16. Informant Minnie SterlingAddress Bonifield17. Burial Burial

(Burial, cremation, or removal. Which?)

Date thereof 8/24/45

(month) (day) (year)

Cemetery or crematory BonifieldLocation Bonifield18. Funeral director Howard D. W. WestheadAddress Bonifield19. 8/25/45

(Date rec'd by registrar)

C. E. Bellino, M.D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty SomersetCity or town Bonifield

(If outside city or town limits, write RURAL and give nearest town)

Street No. State Road

(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 25 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct1944 August 25 1945and that I last saw him alive on August 25 1945

Immediate cause of death

Heart Disease

DURATION

1 monthDue to CircumstancesStarvation

2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

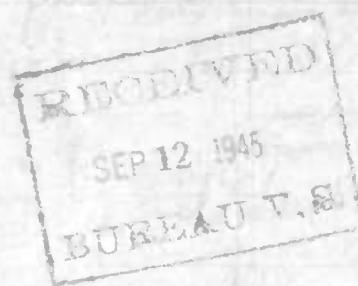
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE George D. Bellino, M.D. M. D. or otherAddress Minnie Sterling Date signed August 25 1945



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

08288

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:

County Somerset
 City or town Crisfield Md
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution: Edw. N. McLeary Mem. Hospital
 Stay in hospital or inst. (yrs., or mos., or days) 10 days
 Stay in this community (yrs., or mos., or days) 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Somerset
 City or town Westover Ward No. _____
 (If outside city or town limits, write RURAL NEAR and give town)
 Street No. _____
 (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME

Emma Rita Thomas4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced WidowedB (b) Name of husband or wife John Thomas

B (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) September 7, 18658. AGE: Years 79 Months 11 Days 23 If less than one day

hrs. _____ min. _____

9. Birthplace Deal Island - Somerset - Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Giles T. Webster13. Birthplace Deal Island, Md14. Maiden name Louisa Kelly15. Birthplace Chance, Md16. Informant Mrs. Dennett LongAddress Westover, Md.17. Burial Date thereof 9-1-45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. John's CemeteryLocation Deal Island, Md18. Funeral director H. Harvey BoddishAddress Crisfield, Md19. Sept 1, 1945 (Date rec'd by registrar) C. E. Collins, M.D.
Registrar

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 194521. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 18 1945 to August 28 1945 and that I last saw her alive on August 28 1945

Immediate cause of death

Acute Del. of heart

DURATION

10 days

Due to

Due to Indirect arterial obstruction, 10 daysDue to atherosclerosis Not due to cancer 10 daysOther conditions Chronic left nephritisChronic nephritis

(Include pregnancy within 3 months of death)

Major findings: Fetal death deliveredOf operations: Fetal death delivered

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE George O. Ballou, M.D.

M. D. or other

Address Musser St. Md Date signed Sept 1, 1945

RECEIVED

SEP 12 1945

LIBRARY OF CONGRESS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 188

CERTIFICATE OF DEATH

08289

Reg. Dist. No. 220

1. PLACE OF DEATH:

County Somerset
City or town Crisfield

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 yrs. 4 mo. 5 da.

Hospital, institution, or street address where death occurred:

Edward W. McCready Memorial Hospital

How long in hospital or institution? 2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Somerset

City or town Crisfield (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

Betty Lee Ward

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 15, 1926

.....(c) If alive, give age years

8. AGE: Years Months Days If less than one day
19 4 5 hrs. min.

9. Birthplace Crisfield-Somerset-Maryland

(Town, county, and state)

10. Usual occupation Factory worker

11. Industry or business War materials

FATHER 12. Name Norris Ward

13. Birthplace Crisfield, Maryland

MOTHER 14. Maiden name Anna Miles,

15. Birthplace Crisfield, Maryland, RFD

16. Informant Norris Ward

Address Crisfield, Maryland

17. Burial Date thereof Aug. 22, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sunnyridge Cemetery

Location Crisfield, Maryland, RFD

18. Funeral director H. Harvey Bradshaw

Address Crisfield, Maryland

19. 8/22/45 (Date rec'd by registrar)

C. E. Collins, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1945, at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw h. alive on 19.

Immediate cause of death

bruised & ruptured liver

DURATION

Due to internal hemorrhage

Due to shock -

horse back riding

Other conditions

horse fell on

H.H. Coulbourn, M.D. (Include name and title of physician)

Major findings of operation DEPUTY MEDICAL EXAMINER

FOR SOMERSET COUNTY, MD.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date Aug. 20, 1945

Where did injury occur? Crisfield, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Hygeia Beach

Method of death Horse fell out of saddle & landed on back

Place of death Crisfield, Md. (City or town) (County) (State)

M. D. or other

Address Crisfield, Md. Date Aug. 23, 1945

Signature C. E. Collins, M.D.

RECEIVED

AUG 30 1945

EXHIBIT 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

08290

CERTIFICATE OF DEATH

Reg. Dist. No. 270

1. PLACE OF DEATH:

Somerset
County.

Crisfield RURAL

(If outside city or town limits, write RURAL and give nearest town)

38 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Georgiana Ward

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Negro Married

6.(b) Name of husband or wife Addo R. Ward

7. Birth date of deceased (mo., day, yr.) January 8, 1887
6.(c) If alive, give age 68 years8. AGE: Years Months Days If less than one day
58 7 3 hrs. min.9. Birthplace Smith Island-Somerset-Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Jefferson Sutton

13. Birthplace Smith Island Md.

14. Maiden name Minnie Hall

15. Birthplace Smith Island Md

16. Informant Addo R. Ward

Address Hopewell Md.

17. Burial Date thereof 8/15/45
(Burial, cremation, or removal. Which?)

Cemetery or crematory Hopewell Cemetery

Location Hopewell Md.

18. Funeral director H. Harvey Bradshaw

Address Crisfield, Md.

19. (Date rec'd by registrar) 8/15 1945 *Deputy Coroner of Md* *C. C. Collins, M.D.* Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Md County Somerset

Crisfield RURAL

(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1945 1030 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 9 1945 to August 11 1945

and that I last saw her alive on August 9 1945

Immediate cause of death *Card. Disease*Secondary cause *Hemiplegia*Due to *closed out vessels**Arteria myocardi*

Due to

Other conditions *Facial vessel Disease*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

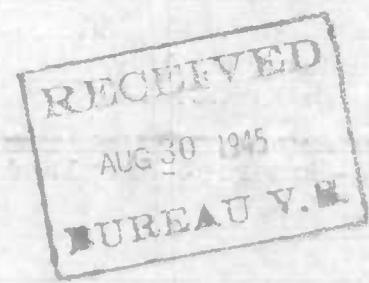
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *June L. Bourne* M. D. or otherAddress *Deputy Coroner of Md* Date signed *Aug 13 1945*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08291

CERTIFICATE OF DEATH

Reg. Dist. No. 208

1. PLACE OF DEATH: Somersby
County. Deaf Island Md

City or town. Deaf Island Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME Frederick Webster

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

7. Birth date of deceased (mo., day, yr.) Jan. 13 - 1910 8. (c) If alive, give age years

8. AGE: 35 Years 0 Months 0 Days 0 If less than one day

9. Birthplace Deaf Island Som Co Md
(Town, county, and state)

10. Usual occupation Sailor

11. Industry or business None

12. Name None

13. Birthplace Deaf Island Md

14. Maiden name Julian Webster

15. Birthplace Deaf Island Md

16. Informant None

Address Deaf Island Md

17. (Burial, cremation, or removal? Which?) Burial Date thereof 8/17/1948

Cemetery or crematory St. Stephens W.E.

Location Deaf Island Md

18. Funeral director None

Address Deaf Island Md

19. (Date rec'd by registrar) Aug. 17 1948

(Date rec'd by registrar) Rosa Webster

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State. None County. None

City or town. None (If outside city or town limits, write RURAL and give nearest town)

Street No. None (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1948 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 14 1948 to Aug. 15 1948 and then I last saw him alive on Aug. 15 1948.

Immediate cause of death Pulmonary Insufficiency

DURATION 1 year

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Frank Waters M. D. or other

Address Princers Arms Date signed Aug 16

